Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|------------|-----------------------------------|---|---------------------------|--|--|
| NVS5314PCA | | NVS5314PCA | | B. WING | | 01/27/2009 | |
| NAME OF PROVIDER OR SUPPLIER PARADISE HOME CAPE 24 | | | 2450 CHAN | CHANDLER AVE #10 VEGAS, NV 89120 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATION | | | ID PREFIX TAG | (EACH CORRECTIVE ACTION S | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE | |
| P 000 | Initial Comments | | | P 000 | | | |
| | This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted in your agency on January 27, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. This findings and conclusions of any investigation by the Health Division shall not be construed as | | 009. by e gation d as | | | | |
| | prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. | | | | | | |
| | The following deficiencies were identified: | | | | | | |
| P 230 | Sec. 16. 1. A separate personnel file must be kept for each attendant of an agency and must include, without limitation: (a) The name, address and telephone number of the attendant; (b) The date on which the attendant began working for the agency; (c) Documentation that the attendant has had the tests or obtained the certificates required by NAC 441A.375; (d) Evidence that the references supplied by the attendant were checked by the agency; (e) Evidence of compliance with NRS 449.179 by the administrator of the agency or the person licensed to operate the agency with respect to the attendant; (f) Proof that, within 6 months after the attendant began working for the agency, the attendant obtained a certificate in first aid and cardiopulmonary resuscitation issued by the American National Red Cross or an equivalent | | er of d the the 79 by dant | P 230 | | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 04/10/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5314PCA 01/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2450 CHANDLER AVE #10 PARADISE HOME CARE LAS VEGAS, NV 89120 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 230 P 230 Continued From page 1 certificate approved by the Health Division: (g) Proof that the attendant is at least 18 years of age; (h) Proof of possession by the attendant of at least the minimum liability insurance coverage required by state law if the attendant will be providing transportation to a client in a motor vehicle; and (i) Documentation of all training attended by and performance evaluations of the attendant. This STANDARD is not met as evidenced by: Based on review of personnel files there were 9 of 13 records that did not have evidence of reference verification as required by subsection (1)(d). Findings include: Review of personnel files revealed a lack of evidence to confirm references were verified prior to hiring for employee number 1, 2, 3, 7, 8, 10, 11 and 12. P 240 P 240 16.1(2) Training Documentation 2. The documentation described in paragraph (i) of subsection 1 must include, without

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limitation, for each training course attended by

(a) A description of the content of the training

(b) The date on which the training course was

(c) The number of hours of the training course;(d) The name and signature of the instructor of

the attendant:

course:

attended:

the training course; and

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5314PCA 01/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2450 CHANDLER AVE #10 PARADISE HOME CARE LAS VEGAS, NV 89120 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 240 Continued From page 2 P 240 (e) A certificate indicating that the training course was successfully completed by the attendant. This STANDARD is not met as evidenced by: Based on review of training records, 2 of 13 records lacked a description of the content of one training course. Findings include: Employee number 4 and number 13 did not have a description of the content of the basic training course completed at another agency prior to hiring.